Chapter 23

Hospice Services

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COVERED SERVICES

Hospice services provide palliative and supportive care for terminally ill ALTCS, KidsCare, and EPSDT recipients and their families or caregivers. Effective 10/1/2007, AHCCCS will cover non-ALTCS recipients 21 years of age and older. A physician must certify that the recipient is terminally ill. Hospice care is limited to those recipients who are in the final stages of a terminal illness (i.e., recipients who have a prognosis of death within six months).

The initial physician certification is effective for 90 days. If the recipient continues to need services, the physician must recertify for a second 90-day period. Subsequent recertifications for 60-day periods are required if the recipient continues to require hospice services.

A hospice uses a medically directed interdisciplinary care team of professionals and volunteers to meet the physical, psychological, social, spiritual, and other special needs which are experienced during the final stages of illness, during dying, and bereavement.

Hospice services include:

- ☑ Nursing services
- ☑ Respite care
- ☑ Bereavement services
- ☑ On-call availability for reassurance
- ☑ Information and referral for recipients and families
- ☑ Social services
- ☑ Pastoral/counseling services
- ☑ Dietary services
- ☑ Homemaker services
- ☑ Home health aide services
- ☑ Therapies
- ☑ Medical supplies, appliances, and DME
- ☑ Pharmaceuticals

Hospice services may be provided in the recipient's home (a nursing facility can be considered a recipient's home) or in an inpatient setting.

COVERED SERVICES (CONT.)

Home care may be provided on an intermittent, regularly scheduled, and/or an on-call, around-the-clock basis according to recipient and family needs.

Non-institutional hospice services may be provided in the recipient's home as long as the recipient's condition remains stable enough for the recipient to remain at home.

BILLING AND AUTHORIZATION REQUIREMENTS

Hospice services require authorization from the ALTCS case manager.

Hospice providers must bill for services on the UB-92 claim form using bill types 81X - 82X. The third digit must be 1 through 4 or 6 through 8.

Payment is made to a hospice provider for only one of four revenue codes. AHCCCS reimbursement rates for the four levels of service are all-inclusive rates that include durable medical equipment, medication, and other health care services (physician) related to the recipient's terminal illness.

Recipients requiring medical services not related to the terminal illness may receive them without having payment for these services included in the all-inclusive rate. Acute medical care services in this instance are non-inpatient services provided to ALTCS eligible recipients who are not covered by Medicare. Acute medical care services must be coordinated between the primary care physician and the case manager.

The following revenue codes may be billed to AHCCCS. (NOTE: Medicare claims with A, B, C, or D in the third digit cannot be processed. They refer only to the Notice of Election for Medicare.)

☑ Revenue Code 651 (Routine home care day)

- ✓ A routine home care day is a day during which a recipient is at home (or in a nursing facility) and not receiving continuous care.
- ✓ Reimbursement is the lesser of the billed charge or the AHCCCS hourly rate multiplied by the number of hours billed.
- ✓ When hospice care is furnished to a fee-for-service recipient in a nursing facility, the hospice should bill only for the routine home care rate.
  - ☒ The nursing facility is reimbursed directly by AHCCCS for the room and board and other services furnished by the facility.

BILLING AND AUTHORIZATION REQUIREMENTS (CONT.)

☑ Revenue Code 652 (Continuous home care day)

- ✓ A continuous home care day is a day during which a recipient receives services consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of crisis as necessary to maintain terminally ill recipients at their places of residence. A minimum of eight hours of care must be furnished on a particular day to qualify for the continuous home care rate.
  - ☒ Home health aide, homemaker services, or both may also be provided on a continuous basis.
  - ☒ Continuous home care is not available to nursing facility residents.
- ✓ Reimbursement is the lesser of the hourly rate multiplied by the hours billed or the per diem rate.

☑ Revenue Code 655 (Inpatient respite care day)

- ✓ An inpatient respite care day is a day during which a recipient receives care in an approved facility on a short-term basis. Institutional (inpatient hospice) services may be delivered at the provider's site or through subcontracted beds in an institutional setting such as a hospital or nursing facility when the recipient's condition is such that care can no longer be rendered in the recipient's home.
- ✓ The inpatient rate is paid from the date of admission up to, but not including, the date of discharge.
  - ☒ For the date of discharge, the appropriate home care rate is paid.
  - ☒ If the patient dies as an inpatient, the inpatient rate is paid for the date of discharge.
  - ☒ Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.

☑ Revenue Code 656 (General inpatient care day)

- ✓ A general inpatient care day is a day on which a recipient receives general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings.
- ✓ The inpatient rate is paid from the date of admission up to, but not including, the date of discharge.
  - ☒ For the date of discharge, the appropriate home care rate is paid.
  - ☒ If the patient dies as an inpatient, the inpatient rate is paid for the date of discharge.

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